

Socio-Demographic Factors, Contraceptive Use and Fertility Preference among Married Women in South-South Region of Nigeria

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Abstract - Nigeria is among a few countries in sub-Saharan Africa with consistently low contraceptive use of 15% among married women whose average fertility rate is 5.5 from the 2013 Nigeria Demographic and Health Survey (NDHS) report. The [21], report showed that while fertility rate of 5.5 in 2013 was a slight drop from previous years of 5.7 in 2003 and 2008, contraceptive use has experienced only a gradual increase of 2% from 2003 figures. This study examines the relationships between socio-demographic factors influencing contraceptive use of married women and how this affects their fertility preferences now and in the future. The study used the 2013 Nigeria Demographic and Health Survey [21] data sets. Analysis employed univariate, bivariate, and multivariate analytical techniques. Results show that some women background factors like state of residence, education, wealth index, and number of other wives have both direct and indirect relationship with contraceptive use. The odds that women used contraceptive method increased significantly by level of education, wealth status, and number of living children, and the odds varied significantly by state of residence, number of other wives, and fertility preference. Effective programming focused on contraceptive increase will need to consider state variations, educational levels, and wealth differences across sub-groups in this region. Other important factors that should be factored into programming are number of co-wives, number of living children per woman, and whether women are favorable or not to having another child.

Key words: *socio-demographic factors, contraceptive use, fertility preference, married women.*

I. INTRODUCTION AND STATEMENT OF PROBLEM

In the year 2000, it was estimated that the population of the world was growing by about 78 million per year at the rate of 1.4%, and was projected to rise to over 8 billion in 2025 [27]. A survey carried out in 1990 among the developing countries,

revealed that total fertility rate was highest in the Sub-Saharan Africa at an average of 5.3 children per woman [3].

Among the black nations in the world today, Nigeria is the most populous and recent estimates indicate a total population of 177 million people [31], with a growth rate of 3.2% and a TFR of 5.5, [21]. These statistics are obviously indicators of an impending population explosion if measures for checks are not considered. In Nigeria today, according to [20], population explosion with the resultant effect of food production not being sufficient for the growing population is already being experienced. In Nigeria, the more children a woman is able to procreate, the matrimonially fulfilled the culture considers her. This attitude is the bane of Nigeria's economic growth and development, [10] confirmed this assertion with an opinion that less developed countries like Nigeria could only grow economically if population growth is held in check.

In the olden days, world over, it was hard for women to decide when next to have a child, the actual number of children and when to stop childbearing, except for women who were highly educated career women [10]. They concluded that the number of children a woman bore reflected the desired fertility of her husband and his relatives. However, in the modern society, women's status is gradually changing. At present, women's traditional household activities are changing due to the influence of various socio-economic and demographic conditions, especially with more women engaging in income generating activities, higher educational status and high decision power in the household especially as it relates to her reproductive health.

Despite this progress made in the status of women world over, Nigeria is still among the few countries in Sub-Saharan Africa with consistently low contraceptives use of 15% among married women whose average rate is 5.5 from the 2013 Nigeria Demographic and Health Survey (NDHS) report. The [21] report showed that while fertility rate of 5.5 in 2013 was a slight drop from previous years of 5.7 in 2003 and 2008,

contraceptive use has experienced only a gradual increase of 2% from 2003 figures.

Although efforts to control fertility in Sub-Saharan Africa are being vigorously pursued, little results have been recorded. This could be attributed to the fact that the economy in the region continues to be agricultural based, with most of the population being predominantly rural. According to [7], marrying early and low levels of contraceptive use continue to be normative in the sub- region. In Nigeria, Contraceptive Prevalence Rate (CPR) is low and according to the report released by the International Women's Health Coalition in 2007, the Contraceptive Prevalent Rate among the cohort of married women aged 15-49 years indicated an all time low of 8% for modern methods and 12% for all methods [1]. In Nigeria, as revealed by [13], adopting modern contraceptive use is a rather difficult and complex issue that is highly influenced by sociological factors, cultural affiliations and religious convictions.

Authors, [2,9, and 25], all reiterated the fact that socio-economic status of women, notably educational levels, cultural and religious values have been argued to explain differences in reproductive behavior and contraceptive choices. In recent times, much research have been undertaken to investigate the socio-demographic characteristics and their association with contraceptive use among women of reproductive age. These socio-demographic characteristics include women age, state of residence, residence (whether urban or rural), educational attainment of the woman, wealth index, marital status, work status of the woman. However, studies on the relationships between socio- demographic factors influencing contraceptive use of married women and how it affects their fertility preferences now and in the future in South – South Region of Nigeria is sparse. This study is designed to address this knowledge gap

A. Nigeria and Fertility

In Africa as well as Nigeria, fertility preference is affected by social norms and biological behaviour. These influences include a high level of mortality among the infants and children, early marriage, early child bearing as well as child bearing within much of the reproductive life span, low use of contraception and high social values placed on child bearing. The Total Fertility Rate (TFR) in Nigeria is 5.5. This means that at current fertility levels, the average Nigerian woman who is at the beginning of her child bearing years will give birth to 5.5 children by the end of her lifetime. Although the Nigerian government in its first population policy in 1988(revised in 2004), that called for a reduction in the birth rate through voluntary fertility regulation methods compatible with the nation's economic and social goals, pegged the number of children per woman at four, the country's Total Fertility Rate (TFR) is still high as 5.5; one of the highest fertility levels in the world. [22].

B. Nigeria and Contraceptive use

In developing countries like Nigeria, unplanned pregnancies abound and this usually results in abortions by untrained persons with resultant cases of diseases and death. In the world nearly 350,000 women die annually while another 50 million suffer from illness and disability from complications as a result of pregnancy related issues and child birth and Nigeria is among the first six countries that contribute to about 50% of maternal death annually [24]. This is alarming, bearing in mind that Nigeria's contraceptive prevalence rate is still quite low even at 15% though it is an increment of about 2% from 2003 NDHS report, [21]. In industrialized countries, virtually all married women resort to contraceptives at sometime in their reproductive period [1], little wonder the fertility rates in those nations are very low. In contrast however, the percentage of people reporting such huge use of contraceptives in developing countries is extremely low. As earlier reported, adopting modern contraceptive use is a very complex sociological issue in Nigeria therefore a study of contraceptive usage in Nigeria is one of the ways for providing inquiry into the factors motivating reproductive behavior. At present, it could be argued that examination of the socio-economic cultural characteristics of contraceptive adopters will provide insights into the causes of observed levels and trends in the fertility differentials in the Nigerian context and that's what this study is set to achieve.

C. Family Planning in Nigeria

Fertility decline is a means of achieving demographic dividend, with the consequent potential of reducing poverty, boosting economic growth and contributing to the overall well-being of families and societies [11]. It has been estimated that in Nigeria, a reduction in fertility by one child per woman would lead to 13% increase in GDP per capita within 20 years and it is important to note that while family planning impacts all the MDG goals, it is most directly associated with MDG 5, improving maternal health [29].

Family planning- the ability of individuals and couples to attain their desired number and spacing of their children through contraceptive use- is one of the most cost-effective public health interventions and is pivotal to reducing the country's fertility [18]. Nigeria's family planning program began in 1964 with the National Family Planning Council of Nigeria. Before the 1980's, however, family planning programs were not a priority for the government of Nigeria and consequently were driven by development partners and non-governmental organizations. Following analysis of the consequences of unregulated population growth on health and development in Nigeria, starting in the late 1980's the country began formulating various policies aimed at improving reproductive health outcomes and reducing fertility levels through family planning [6].

Recently, following the 2012 London Summit on family planning, Nigeria developed a blue print for accelerating

uptake of family planning with a target of increasing the national contraceptive prevalence rate to 36% by 2018 [8].

Currently, family planning services are provided by both the public and private sectors, with the commodities provided free in public sectors facilities. In spite of the various investments in family planning programs in the country, it is saddening to know that contraceptives prevalence has not shown any sign of increasing. According to the [21], while knowledge of contraceptives is generally high, uptake is low; only 15% of married women of reproductive age are using any contraceptive method, only 10% are using modern family planning method, while unmet need for contraception is 16%. Therefore, the promotion of family planning in countries with high birth rates has the potential to reduce poverty and hunger and avert 32% of all maternal deaths and nearly 10% of childhood deaths.

II. LITERATURE REVIEW

Fertility is a complex phenomenon that is enormously affected by cultural conditions, preferences and family structures. More so, demand for children is affected by factors such as socio-economic status, and components of demography. The various socio-economic and demographic factors such as level of education, standard of living, working status, number of living children etc have a great impact on prevalence of contraception using and ultimately lower fertility. Contraception Use, which is one of the determinants of fertility [12], has a great impact on fertility, but this awareness has not been fully harnessed by some less developed countries. As a matter of fact modern contraceptives use persists to be low in most African countries, where fertility is high, population growth is escalating and unmet need for family planning is high. Therefore, an understanding of the factors that influence contraceptive use is critical to all the efforts being put in place to produce programmes that will increase prevalence [4].

Writers have different opinions on the exact factors that affect contraceptive use and fertility behavior but there is a general consensus that socio-economic, demographical factors and attitude of women are key, to the use of contraceptive in less developed countries where fertility rate is still high. In their work [6] explored the role of contextual factors in determining use of modern contraceptives in Nigeria. The study used Secondary data from the 2013 Nigeria Demographic and Health Survey (NDHS) among women aged 15-49. The result showed that, generally in Nigeria, individual and community level variables accounted for 82% of the variations in contraceptive use in Nigeria. The contextual factors found to be positively associated with use of modern contraceptives were female education, female autonomy and access of health facilities; while communities with higher proportions of Muslim and higher proportions of polygynous marriages negatively predicted use of modern contraceptives.

In an attempt to determine the prevalence and determinants of choice of contraceptive methods among rural women in Osun State Nigeria, [1] found that the most significant socio-demographic determinants of ever use of contraceptives were religion and family setting. Similarly, [16], studied the impact of religion on the decision to use contraception among Muslim families in India and found that, individual beliefs held by men and women about their religion and what it prescribes or proscribes concerning contraceptive use ultimately affects their demographic decisions.

According to [17], in their study “the variation and factors influencing modern contraceptives use among married women in Ethiopia; evidence from a national population survey”, found that being wealthy, more educated, employed, having higher number of living children, being in a monogamous relationship, attending community conversation, being visited by health workers at home predicted use of modern contraception, while living in the rural areas, older age, being in polygamous relationship and witnessing one’s own child’s death were found to negatively influence modern contraceptive use. The findings indicate a significant socio-economic, urban, rural and regional variation in modern contraceptive use among reproductive age women in Ethiopia. Similarly, [19] studied the socio-economic and demographic factors affecting contraceptive use in Malawi using the 2000 and 2004 DHS Surveys. The study revealed that, the major determinants of contraceptive use are age, respondent’s and partners’ approval of family planning, family planning discussions with partner, number of living children, work status, education and visit to a health center.

Furthermore, [26] in his work, socio-economic and cultural differentials in contraception usage among Ghanaian women, found that the use or non-use of contraception in Ghana is affected by a multitude of demographic, socio-economic and cultural factors. The study reveals that high socio-economic development and modernizing influence on women help to promote contraception, thus, reduce fertility. The study made use of Secondary data from the Ghana Fertility Survey (GFS) 1979/80 under the auspices of the World Fertility Survey. Available evidence as gleaned from these studies explicitly portrays the enormous effect of socio-demographic factors on contraceptive use especially among married women in less developed countries, but studies on the relationships between these socio-demographic factors and their influence on contraceptive use of married women and how it affects their fertility preference now and in the future is scarce. Therefore, this paper is poised to address this gap as it relates to the married women aged 15-49 in South-South Region of Nigeria.

III. DATA & METHODS

The 2013 National Demographic and Health Survey (NDHS) is a national sample survey collected on fertility levels, marriage, fertility preferences, among other vital information. The 2013 NDHS sample was selected using a stratified three-stage cluster design consisting of 904 clusters, 372 in urban

areas and 532 in rural areas. A representative sample of 40680 households was selected for the survey, with a minimum target of 943 completed interviews per state. A complete listing of households and a mapping exercise were carried out for each cluster from December 2012 to January 2013, with the resulting lists of households serving as the sampling frame for the selection of households. A fixed sample take of 45 households were selected per cluster. All women aged 15-49 who were either permanent residents of the households in the 2013 NDHS sample or visitors present in the households on the night before the survey were eligible to be interviewed. A total of 38,948 respondents were administered structured questionnaire (NDHS, 2013). The study analysis focuses mainly on 6058 women in the south-south region of Nigeria.

A. VARIABLES DEFINITION

1) Dependent Variable

The main variable in this analysis is contraceptive use defined as; (1) using, or (2) not using. The analysis has been restricted to this category of women because of the expectation that fertility- related policies and contraceptive regulations are likely to be more meaningful to, and become more successful when adopted by women who are exposed to child bearing oriented sexual relations throughout their reproductive ages.

2) Independent Variables

The main predictor variables are the socio- demographic factors influencing women's employment status and they include; age, residence, education, religion, state of residence, marital status, number of co-wives, wealth status index, age at first sex, and living arrangement.

The intervening variables include:

No. of living children: It is categorized into; none and 1 or more.

Fertility Preference: It is categorized into; favourable to another child and not favourable to another child.

IV. RESULTS

A. Study Sample Description

The majority of women were aged 29 or younger (57%), lived in the rural areas (66%), and had secondary/higher education (69%). Most women were Christians (97%), in a monogamous union (82%), had first sexual debut at age 19 or younger (80%), and lived with their husbands (84%). Respondents were fairly evenly distributed the six states in the region; Bayelsa (20%), Delta (19%), Edo (18%), Akwa Ibom (16%), Rivers (15%), and Cross River (12%). Majority of respondents were employed (65%), earned cash only (78%), and were in the rich/richest socioeconomic bracket (63%). About 25% of respondents had one or two children, 18% had three or four, and 19% had 5 or more, while 38% do not have any. Results show that only 26% of the women who

participated in the survey reported using contraceptive methods.

B. Multivariate Results

The result of the binary logistic regression model is presented as relative odds in table 2. The reference category of each measured independent variable has a value of one and the values for other categories are compared to that of the reference category. Results of this study (Table 2), show that some women background factors like state of residence, education, wealth index, and number of other wives have both direct and indirect relationship with contraceptive use. The odds that women used contraceptive method increased significantly by level of education, wealth status, and number of living children, and the odds varied significantly by state of residence, number of other wives, and fertility preference.

Model 1: Contraceptive Use by background factors

Rivers State women were 1.5 times as likely as women from Edo State to use contraceptive. Women from Bayelsa State were 0.45 times as likely as women from Edo State to use contraceptive. With regards to educational level, respondents with primary education were 1.8 times as likely as women with no education to use contraceptive, while women with higher education were found to be 2.5 times as likely as women with no education to use contraceptives. Women in the richer wealth category were 1.7 times as likely as women in the "poorest/poorer" category to use contraceptives and respondents in the richest wealth category were 1.8 times as likely as women in the "poorest/poorer" category to use contraceptives. With respect to the number of co-wives, women with one or more co-wives were 0.62 times as likely as women with no other wife to use contraceptives.

Model 2: Contraceptive use by fertility behavior factor

Results in Table 2 show that women with one or more living children were 0.81 times as likely as women with no living children to use contraceptives. With regards to fertility preference, women who were not favorable to having other children were 1.3 times as likely as their counterparts favourable to another child to use contraceptives.

Model 3: Contraceptive use vs. background & fertility behavior factors

Results in Table 2 show that women in Delta State were 1.47 times as likely as women from Edo State to use contraceptive method. So also are women from Rivers State who were 1.62 times as likely as women from Edo State to use contraceptives. Also, respondents from Bayelsa State were 0.50 times as likely as respondents from Edo State to use contraceptives. In terms of education, women with secondary education were 2.6 times as likely as women without education to use contraceptives, while women with higher education were 2.9 times as likely as women without education to use contraceptives. In the wealth index category, the women in the richer categorized were 1.9 times as likely as women in the poorest/poorer category to use contraceptives.

Women in the richest wealth index were 2.1 times as likely as women in the reference category to use contraceptive. Women who had co-wives were 0.62 times as likely as women with no co-wife to use contraceptives. Women with 1 or more living children were 3.3 times as likely as women with no living children to use contraceptives. As regards to fertility preference, women that are not favourable to having another child were 2.3 times as likely as women that favour another child to use contraceptives.

V. DISCUSSION & CONCLUSION

This study was geared to examine the relationships between women's background factors and their fertility behavior with contraceptive use at the south-south region of Nigeria with a view to providing useful information for stakeholders to increase contraceptive use in the region. Results show that effective programming focused on contraceptive increase will need to consider state variations, educational levels, and wealth differences across sub-groups in this region, this was

found to be consistent with several studies conducted in developing countries (C. L. Ejembi, T. Dahiru and A. A. Aliyu, (2015) and L. Yihunia, A. Ayalu, T. Habtamu, B. Susan and D. Kebede, 2013). Other important factors that should be factored into programming are number of co-wives, number of living children per woman, and whether women are favorable or not to having another child, this is also consistent with previous studies [18, 19]. Fertility preference may differ depending on the stage of a woman in her reproductive life cycle but a salient cultural factor that this study brings to bear is seeming competition among co-wives which may not be overt but may be a key reason for desire for another child among women in polygamous relationship in the region. This study confirms [6] findings from Nigeria that higher proportions of polygynous marriages negatively predicted use of modern contraceptives.

Table 1: Background characteristics of the respondents

Variable	Frequency (N=6,058)	Percentage (%)	Variable	Frequency (N=6,058)	Percentage (%)
Respondent age			State of residence		
5-19	1376	22.7	Edo	1079	17.8
20-24	1063	17.5	Cross River	727	12.0
25-29	1027	17.0	Akwa Ibom	979	16.2
30-34	803	13.3	Rivers	919	15.2
35-39	737	12.2	Bayelsa	1224	20.2
40+	1052	17.4	Delta	1130	18.7
Residence			No of Co-wives		
Rural	3996	66.0	No other wives	2696	82.3
Urban	2062	34.0	One or more	578	17.7
Educational level			Marital Status		
No education	336	5.5	Never in union	2344	38.7
Primary	1549	25.6	Married together	3308	54.6
Secondary	3483	57.5	Married not together	406	6.7
Higher	690	11.4	Age at first Sex		
Religion			15 or younger	1130	30.5
Islam-trad	171	2.8	16-19	1829	49.4
Catholic	555	9.2	20 or older	744	20.1
Other Christian	5302	88.0	Living arrangement		
Wealth index			wife living with husband	2773	84.2
Poorest-poorer	620	10.2	wife living elsewhere	521	15.8
Middle	1599	26.4	Employment Status		
Richer	2060	34.0	Not working	2131	35.4
Richest	1779	29.4	Working	3896	64.6
Earnings			No. of Liv. Children		
Not paid	474	13.3	None	2285	37.7
Cash only & 1 kind	3083	86.7	1 or more	3773	62.3
Fertility preference			Contraceptive use		
Favourable to another Child	4750	79.3	Not using	4468	73.8
Not favourable to another Child	1243	20.7	Using	1590	26.2

Table 2: Logistic Regression Analysis of Contraceptive Use and Fertility Behaviour, Background Factors.

Variable	Model 1 (Contraceptive use by Background Factors)	Model 2 (Contraceptive use by Fertility Behavior)	Model 3 (Contraceptive Use by Fertility Behavior by Background factors)
Age			
15-19	1.00		1.00
20-24	1.195		1.032
25-29	1.057		0.801
30-34	1.010		0.648
35-39	1.423		0.772
40+	1.061		0.449
State of Residence			
Edo	1.00		1.00
Cross river	1.374		1.235
Akwa Ibom	1.083		1.025
Rivers	1.530*		1.629**
Bayelsa	0.153***		0.502**
Delta	1.380		1.472+
Educational Level			
No Education	1.00		1.00
Primary	1.840*		1.934
Secondary	2.489**		2.625**
Higher	2.528**		2.971***
Wealth index			
Poorest-poorer	1.00		1.00
Middle	1.025		1.004
Richer	1.726**		1.904**
richest	1.808**		2.143**
Age at first Sex			
15 or younger	1.00		1.00
16-19	0.957		1.028
20 or older	0.809		0.966
Religion			
Islam-Trad	1.00		1.00
Catholic	1.861		1.973
Other Christian	1.166		1.259
No. of co-worker			
No other wife	1.00		1.00
One or more	0.622**		0.626**
Place of residence			
Rural	1.00		1.00
Urban	0.872		0.856
Living arrangement			
Wife with Husband	1.00		1.00
Wife living elsewhere	0.917		0.925
No. of Living Children			
None		1.00	1.00
1 or more		0.812**	3.370***
Fertility Preference			
Favourable to another child		1.00	1.00
Not favourable to another child		1.337***	2.337***
Model chi square	455.195	1271.190	472.313
Nagelkerke R Square	0.093	0.004	0.144
-2log likelihood	2146.110	6838.729	2002.575

REFERENCES

- [1] A. I. Olugbenga- Bello, O. L. Abodunrin and A. A. Adeomi, "Contraceptive Practices Among Women in Rural Communities in South- Western Nigeria," Global Journal of Medical Research, Volume 11, Issue 2, Version 1.0, 2011.
- [2] A. Malhotra, V. Reeve, and K. Sunita, "Fertility, dimensions of patriarchy, and development in India", Population and Development Review; 21: pp. 281-305, 1995.
- [3] A. Olalekan, E. Asekun-Olarinmoye, B. Olusegun, and A. Olugbenga, "A Comparative Study of Socio-Demographic Determinants and Fertility Pattern Among Women in Rural and Urban Communities in South-Western Nigeria", Wilolud Journals, Continental J Medical Research 5 (1): pp. 32-40, 2011.
- [4] A. O. Oyedokun, "Determinants of Contraceptive Usage: Lessons from Women in Osun State, Nigeria," Journal of Humanities and Social Sciences, volume 1, issue 2, 2007.
- [5] B. Cohen, "The Emerging Fertility Transition in Sub-Saharan Africa," World Development, 26(8): 1431-1461, 1988.

- [6] C. L. Ejembi, T. Dahiru, and A. A. Aliyu, "Contextual Factors Influencing Modern Contraceptive Use in Nigeria", A DHS working paper, USAID, NO.120, 2015.
- [7] D. C. Mustapha and Z. I. Mohammed, "Male Knowledge, Attitudes and Family Planning Practices in Northern Nigeria," *African Journal of Reproductive Health*, Vol. 10, No. 3, pp 53-65, 2006.
- [8] Federal Republic of Nigeria, "National HIV and AIDS and Reproductive Health Survey 2012", Edited by the Department of Reproductive Health Abuja- Nigeria: Federal Ministry of Health, 2014.
- [9] J. Caldwell, "Demographic Change in Rural South India," *Population and Development Review*, 1982.
- [10] J. C. Caldwell, and C.P. Caldwell, "Family Planning Programs in the Twenty-First Century Studies in Family Planning", Vol. 33, No. 1: pp 76-86, 2002.
- [11] J. Cleland, S. Bernstein, A. Ezeh, [A. Faundes, and A. Glasier, 2006. Family Planning: the unfinished agenda. *Lancet*, 368 (9549): 1810-1827.
- [12] J. F. Bongaarts, and R. Lesthaeghe, "The Proximate Determinants of Fertility in Sub Saharan Africa," *Population and Development Review*, 10 (3), 1984.
- [13] J. -Hanks, "Time and Social Context of Fertility, Population and Development Review; 28(2) 229-249.
- [14] J.V.Allman, Q. N. Nguyen, M.T. Pham, B. S. and D.M Vu, "Fertility and family planning in Vietnam, *Studies in family planning*," 22(5), pp. 308-17, 1991.
- [15] R.J. Lapham, and W. P. Mauldin, "Contraceptive prevalence: the influence of organized family planning programmes," *Studies in Family*, pp 6-13, 1985.
- [16] L. Sriya, "Religion and The Decision to Use Contraception in India," *Journal for the Scientific Study of Religion*, Vol. 41(4) pp. 711-722, 2002.
- [17] L. Yihunie, A. R. Ayalu, T. Habtamu, B. Susan and D. Kebede, "Geographical Variation and Factors Influencing Modern Contraceptive use among Married Women in Ethiopia: Evidence from a National Population Based Survey; *Reproductive Health*", 10:52, 2013.
- [18] M. Graff, and J. Bremner, "A practical guide to population and development," Washington: Population Reference Bureau, 2014.
- [19] M. E. Palamuleni, "Socio-Economic and Demographic Factors Affecting Contraceptive use in Malaw," *African Journal of Reproductive Health*; 17(3): 91, 2013.
- [20] M. Khurfeld, "In Thousands feared born in Nigeria's population explosion," *The Onion*, www.theonion.com, 2006.
- [21]
- [22] National Population Commission (2009).
- [23] National Population Commission and ICF Macro: Nigerian Demographic and Health Surveys, 2013 Abuja, Nigeria: National Population Commission and ICF Macro, 2014
- [24] P. E. Obasahon, "Religion, ethnicity and contraceptive use among women of reproductive age in Nigeria," *International Journal of Mch and Aids* 3 (1): 63-73, 2015.
- [25] S. Kazi, and Z. Sathar, "Explaining fertility in rural Punjab: The relative roles of gender and development" In E. J. Phillips, and Z. Sathar, "Fertility transition in South Asia", Oxford: Oxford University Press, 2001.
- [26] S. Y. Oheneba, "Determinants of Current Contraceptive Use among Ghanaian Women at the Highest Risk of Pregnancy," *Journal of Biosocial Science* 24: 463-475, 1990.
- [27] UNFPA (United Nations Funds for Population), 1999.
- [28] UNFPA (United Nations Funds for Population), "Myths, Misrepresentations and fear, Addressing condom use barriers," Occasional Publication, 2007.
- [29] UNFPA and PATH, "Reducing unmet need for family planning: Evidence-based strategies and approaches," Outlook, New York: UNFPA, 2008.
- [30] UNFPA (United Nations Funds for Population", "Reproductive Health, Ensuring that Every Pregnancy is Wanted," <http://www.unfpa.org/rh/planning.htm>., 2012.
- [31] World Population Bureau, 2014.



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